Massachusetts Department of Mental Health

CONSENT FORM FOR PSYCHIATRIC TREATMENT

Pursuant to DMH Policy # 96-3

Name:	
Date:	
Record # :	

Introduction: This form is to be completed and signed by an authorized prescribing clinician and by the client, or by the guardian with appropriate authority of an incompetent client, or by the parent/guardian with appropriate authority of a minor child for whom psychiatric treatment is being recommended.

My authorized prescribing clinician met with me and we talked about: a) condition(s), for which treatment is being recommended; b) recommended treatment; c) dosage of medication, and how I will take it (by mouth or injection); d) duration of treatment (no more than one year at a time); e) desirable outcomes of the proposed treatment (prognosis with treatment); f) risks, benefits and side effects of the treatment;* g) dangers of abruptly discontinuing medications and how to safely discontinue medications; h) feasible alternative treatments, including benefits, risks, and probable effectiveness of each; and i) possible outcomes if no treatment is received. The information I was given for each treatment is summarized below. I also received written information about the proposed treatment and accepted the following treatment(s):

1) _____
_____
_____

Client; Parent/Guardian Initials:_____

2) _____
_____
_____

Client; Parent/Guardian Initials:_____

3) _____
_____
_____

Client; Parent/Guardian Initials:_____

4) _____
_____
_____

Client; Parent/Guardian Initials:_____

*THE COMPLETE RANGE OF SIDE EFFECTS IS DISCUSSED ON THE ATTACHED FACT SHEETS

The client received oral/written (circle type of information given) information about the proposed treatment and orally ACCEPTS:

Treatment (Medication):

1. _____ 3. _____
2. _____ 4. _____

I have received information about the proposed treatments and REFUSED:_____
_____Client; Parent/Guardian Initials:_____

I understand I have the right to revoke my consent or refusal to any treatment.

Client Signature: _____ Date: _____

Guardian/Parent Signature: _____ Date: _____

Authorized Prescribing Clinician Signature: _____ Date: _____

White - Medical Record ***Pink - Client*** ***Goldenrod - Guardian/Parent***